Department of Veterans Affairs **VHA DIRECTIVE 2006-045**
Veterans Health Administration
Washington, DC 20420 **July 26, 2006**

MONITORING USE OF THE "-GR" BILLING MODIFIER

1. PURPOSE: This Veterans Health Administration (VHA) Directive provides instructions and requirements for the routine monitoring and auditing of the use of the newly created "-GR" billing modifier for the coding and billing of care which is delivered, in whole or in part, by physician residents at Department of Veterans Affairs (VA) medical centers and clinics.

2. BACKGROUND

a. In partnership with its academic affiliates, VHA is the largest single provider of graduate medical education in the country. More than half the country's physicians have had experience as residents in a VA medical center. Participation in the training of the next generation of physicians is one of VHA's key missions.

b. In non-VA facilities, the Department of Health and Human Services (HHS) Center for Medicare and Medicaid Services (CMS) has historically required the supervising practitioner to be physically present during a patient care encounter in order to bill Medicare for that service. CMS pays for resident salaries through the indirect and direct medical education supplements to Medicare payments; therefore, the supervisor's presence is required in order to provide (and bill) for a separate and identifiable service. CMS guidelines do not apply to VHA, and the supervision rules are based solely on the needs of the patient and the learner.

c. To facilitate billing third-party payors for services provided in whole or in part by residents, VHA requested CMS to provide a new billing modifier which more precisely describes how services are delivered through VHA's graduate medical education programs. In response to VHA's request, CMS has approved a new permanent Healthcare Common Procedural Coding System (HCPCS) Level II billing modifier designated "-GR", the description of which is: "These services were provided in whole or in part by a resident at a VA medical center or clinic, supervised in accordance with VA policy."

d. This modifier is effective for encounters with dates of service on and after January 1, 2006.

e. Use of the "-GR" modifier is governed by current VHA policy. This policy provides, in part, that the modifier is appended to Common Procedure Terminology -4 (CPT-4) procedural codes for an encounter only when clinical documentation shows that a resident provided all or part of the care, and the resident was supervised in accordance with VHA Handbook 1400.1. Policy also provides that use of the "-GC" modifier is entirely discontinued for dates of service on and after January 1, 2006, and that use of the "-GE" modifier is also to be discontinued except for those clinics which had previously received CMS approval to use it.

f. The availability of the "-GR" modifier as a discrete code offers VHA:

(1) Enhanced opportunities in both clinical and business domains;

(2) An improved mechanism to bill for properly supervised resident services; and

(3) Enhanced methods for ensuring that residents are properly supervised and that such supervision is adequately documented.

3. POLICY: It is VHA policy that the use of the HCPCS Level II "-GR" modifier is monitored and audited for both clinical and business accuracy.

4. ACTION

a. **Facility Director.** The facility Director is responsible for:

(1) Ensuring that the Health Information Management (HIM) Program supporting clinical coding functions has internal quality monitoring programs in place which meet the requirements of VHA Handbook 1907.1, to ensure that:

(a) The "-GR" modifier is attached to billable CPT codes only by a coder within HIM, and only when clinical documentation demonstrates that resident services are properly supervised.

(b) The use of the "-GC" modifier is discontinued and the "-GE" modifier is used only as specifically permitted by current VHA policy.

(c) Accuracy of these coding assignments is monitored, and that the monitoring results and corrective actions taken, or to be taken as a result of monitoring results, are included in routine reporting to the organizational elements to which HIM reports. The monthly reports must be delivered not later than the last business day of each calendar month, to the medical center Compliance and Business Integrity Officer (CBIO).

(d) The internal quality monitoring programs required by subparagraph 4a(1) are reasonably adequate to prevent errors from being made in the first instance, to promptly detect errors when they occur, and to correct both the error and the causes for the error when detected. ***NOTE*:** *The monitoring protocols in Attachment A assist in meeting these goals.*

***NOTE**: Medical center Directors retain accountability for the accuracy of billings issued by their sites even though billings may result from coding and billing activities conducted by consolidated operations or contractors* (*see subpar. 5d, 5e, and 5f).*

(2) Ensuring that the Chief of Staff (COS), Associate Chief of Staff (ACOS) for Education, and Service Chiefs for any clinical service which has a graduate medical education program, have internal quality monitoring programs in place that ensure:

(a) Medical residents in graduate medical education programs are supervised by attending physicians in accordance with VHA Handbook 1400.1.

(b) When care is delivered in whole, or in part, by residents, clinical records of that care documented in each case:

1. Identify the supervising physician and

2. Include sufficient details regarding the supervision so that HIM staff can make an accurate determination as to whether a "-GR" modifier can be appended to appropriate billing codes.

(c) There is continual internal monitoring of documentation of resident supervision and that monitoring results and corrective actions taken, or to be taken as a result of monitoring results, are included in routine reporting to the medical center Director, the Veterans Integrated Service Network (VISN) Chief Medical Officer, and in monthly reports, delivered not later than the last business day of each calendar month, to the medical center CBIO.

(d) The internal quality monitoring programs required by subparagraph 4a(2) is reasonably adequate to prevent errors from being made in the first instance, to promptly detect errors when they occur, and to correct both the error and the causes for the error when detected. ***NOTE:*** *The monitoring protocols in Attachment A assist in meeting these goals.*

(3) Ensuring that CBIO supporting VISNs, medical centers, or consolidated billing units support the required monitoring activity by:

(a) Not later than the 5th working day of each calendar month, delivering to clinical and HIM leadership monthly reports of:

1. Whether the "-GC" and "-GE" modifiers were used on billable encounters during the previous calendar month; and

2. All usages of the "-GR" modifier on billable encounters during the previous calendar month.

3. All potentially billable clinical encounters in which services were provided in whole or in part by a medical resident, and which were not billable because a "-GR" (or, when permitted, a "-GE" modifier) was not attached.

(b) Entering results of the routine monthly monitoring (as reported by HIM and clinical leadership) into a national reporting system established by the national CBI Office. If any routine monitor or periodic audit shows accuracy rates in the use of the "-GR" modifier to be less than 95 percent, CBIO must, in addition to the entry in the national reporting system, make an entry in the CBI Compliance Inquiry Reporting and Tracking System (CIRTS) as to the accuracy rate, recommendations made, corrective action taken, and the results of that corrective action.

(c) Reviewing the routine monthly monitoring, (as reported by HIM and clinical leadership); consulting with HIM and clinical leadership, as appropriate; providing analyses; and making recommendations to HIM and clinical leadership, as warranted by the results of the monitoring.

(d) Delivering the analyses and recommendations, which are warranted by the results of the reports, to HIM and clinical leadership, the CBIO's supervisor, the VISN Chief Medical Officer, and to the VISN CBIO. Any recommendation made as a result of any review of monitoring activity must be entered into CIRTS at the time the recommendation is made.

(e) Being in a position to reasonably ensure VISN and medical center leadership that the internal quality monitoring systems are reasonably adequate to prevent errors from being made in the first instance, to promptly detect errors when they occur, and to correct both the error and the causes for the errors when detected. ***NOTE:*** *The monitoring protocols in Attachment A assist in meeting these goals.*

NOTE: *In general, internal quality monitoring systems by operational units can be considered to be reasonably adequate, if the results from properly structured and executed formal external audits by CBI confirm the internal monitoring results, and if appropriate corrective actions are promptly taken based on monitoring results, or based on audit results when necessary.*

(f) Either conducting or arranging for periodic formal external audits of the assignment of the "-GR" modifier to billable encounters, and the usage of the "-GC" and "-GE" modifiers. These audits may be incorporated into, or be components of, other formal audits of coding accuracy which are conducted or arranged for by CBIO.

(g) Making any recommendations warranted by results of audit activity, and entering all such recommendations into the CBI CIRTS system at the time the recommendation is made.

(h) Providing reports of audit activity, reports of audits, reports of corrective action taken, and results of corrective action to the medical center Compliance Committee and to the VISN Chief Medical Officer.

b. **Chief Officer, VHA Office of Compliance and Business Integrity (CBI).** The Chief Officer, VHA CBI is responsible for:

(1) Consulting with the VHA Office of Academic Affiliations, the Chief Business Office (CBO) and the Office of Information-HIM to enhance or modify, as necessary, the monitoring protocols established in Attachment A of this Directive. ***NOTE:*** *The Health Data and Informatics and CBO anticipate creation of standardized national reports using claims scrubber software (currently QuadraMed) which can collect and report the data required for these monitors. When those reports are developed and validated, CBI is to modify the protocols to replace the Fileman routines with the national standard reports.*

(2) Establishing a national reporting system to receive internal monitoring data compiling results of internal monitoring data as reported, as well as audits, recommendations, and follow-up reported via CIRTS, for routine reporting to the national Compliance Advisory Board, and as appropriate, to the Under Secretary for Health.

(3) Making recommendations, as appropriate, to the VHA Office of Academic Affiliations, the VHA Office of Health Data and Informatics, VISNs, medical centers, and the Under Secretary for Health.

(4) Consulting and collaborating with VISN and medical center leadership and their respective CBIOs to support their implementation of local responsibilities under this Directive.

c. **VHA Office of Academic Affiliations.** The VHA Office of Academic Affiliations is responsible for:

(1) Consulting and collaborating with program offices, VISNs, medical centers, and their respective academic affiliates to:

(a) Support proper supervision of medical residents in accordance with Handbook 1400.1,

(b) Support the development of policy for, and assist field facilities in, the effective documentation of resident supervision in accordance with Handbook 1400.1,

(c) Assist medical centers and VISNs in the interpretation of what constitutes the proper assignment of the "-GR" (and, where permitted, the "-GC") modifier to billable encounters by coding staffs, and

(d) Support the prompt implementation of corrective action.

(2) Consulting and collaborating with the national CBI Office, CBO, and the Office of Health Data and Informatics to support, as necessary, the modification of the monitoring protocols in Attachment A as necessary.

d. **VHA Office of Health Data and Informatics.** The VHA Office of Health Data and Informatics is responsible for:

(1) Consulting and collaborating with VISNs and medical centers to:

(a) Support proper and effective documentation of resident supervision in accordance with Handbook 1907.1,

(b) Support the proper assignment of the "-GR" (and, where permitted, the "-GE") modifier to billable encounters by coding staffs, and

(c) Support the prompt implementation of corrective action.

(2) Consulting and collaborating with the national CBI Office, the CBO and the VHA Office of Academic Affiliations to support, as necessary, modification of the monitoring protocols on Attachment A as necessary.

5. REFERENCES

a. Office of Management and Budget (OMB): Circular A-123, http://www.whitehouse.gov/omb/circulars/a123/a123_rev.html.

b. VHA Handbook 1400.1.

c. VHA Handbook 1907.1.

d. Department of Health and Human Services (HHS) Office of Inspector General (OIG) "*Compliance Program Guidance for Hospitals*," 63 Federal Register (FR) 8987, 8988, Section 1(A).

e. HHS OIG "*Small Group Physician Practices Guidance*," 65 FR 59434, 59477, Section III(A).

f. HHS OIG "*Third Party Billing Company Guidance,*" 65 FR 70138, 70139, Section 1.

6. FOLLOW-UP RESPONSIBILITY: The CBI Officer (10B3) is responsible for the contents of this Directive. Questions may be addressed to 202-501-1831. Questions concerning the use of the "GR" modifier need to be referred to Office of Health Data and Informatics at 202-273-9220. Questions concerning resident supervision and documentation requirements regarding the use of the "GR" modifier need to be referred to the Office of Academic Affiliations at 202-357-4010.

7. RESCISSIONS: None. This VHA Directive expires July 31, 2011.

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Under Secretary for Health

Attachment

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ATTACHMENT A

MONITORING PROTOCOLS

The Chief Compliance and Business Integrity Officer (CBIO) must distribute three Fileman routines to the field along with implementing instructions.

1. Monitoring of Discontinuance of the "-GC" and "-GE" Modifiers. The first Fileman routine must extract for systemic internal monitoring all bills on which the "-GC" and "-GE" modifiers have been attached to encounters with a date of service on or after January 1, 2006. ***NOTE:*** *This protocol assumes that the "-GC" modifier has been discontinued in all cases. There are a very limited number of medical centers which may continue to use the "-GE" modifier as provided in current Veterans Health Administration (VHA) policy. At these medical centers only, encounters to which the "-GE" modifier is attached must not be considered an error, but instead is included for monitoring and auditing purposes with the encounters to which the "-GR" modifier is attached.*

a. Medical center CBIOs must arrange to have this routine run at the beginning of each calendar month, distribute the results, and collaborate with the Healthcare Information Management Systems (HIMS) designee by the 5th working day each month. If the report shows "-GC" or "-GE" modifier usage, the HIMS designee reports the causes of the incorrect usage and any action taken to correct the errors not later than the last working day of the month.

b. This Fileman is run on a monthly basis until success in discontinuance of the "-GC" and "-GE" modifier is shown by the monitoring results.

c. When two successive monthly reviews show no use of the "-GC" or "-GE" modifiers during those months, the review may be then conducted at the end of each calendar quarter.

d. When four successive quarterly reviews show that no "-GC" or "-GE" modifiers were attached to an encounter, this review may be conducted on an annual basis.

e. If any quarterly or annual review shows use of either the "-GC" or "-GE" modifier, monthly audits must be resumed and this protocol repeats.

f. Success in this process is measured by the demonstrated continued non-use of the "-GC" or "-GE" modifier, except where the use of the "-GE" modifier is permitted by current VHA policy.

2. Monitoring of Use of the "-GR" Modifier. The second Fileman routine extracts all bills on which the "-GR" modifier is used during a particular calendar month, for systemic monitoring of the appropriate attachment of the modifier.

a. CBIO arranges to have this routine run at the beginning of each calendar month and distributes the list of bills using the "-GR" modifier to the HIM designee by the 5th working day

each month. ***NOTE:*** *Where a medical center is permitted by current policy to continue use of the "-GE" modifier, encounters to which that modifier is attached must be included in the list.*

b. The HIM designee selects a valid random statistical sample from the list of bills, and reviews or arranges to have the underlying documentation for each of the encounters in the statistical sample reviewed by a coder who was not involved in the initial coding, to determine if the "-GR" code was properly attached by a coder to the encounter. Results from the review of the statistical sample are reported to CBIO not later than the last working day of the calendar month. ***NOTE:*** *Statistical samples are randomly selected from the listings produced by the Fileman routine. The number of records selected for and the method of selection of a valid statistical sample must be sufficient to provide 95 percent confidence of 5 percent precision in the results, as determined via the Attribute Sampling module in the RAT-STATS Program available from the Office of Audit Services, Office of Inspector General (OIG), Department of Health and Human Service (HHS), which can be downloaded from http://oig.hhs.gov/organization/OAS/ratstat.html. Documentation of the method of sample selections must be retained with monitoring work papers.*

c. If the results of review of the random statistical sample for 2 consecutive months show coding accuracy of 95 percent or more, then during successive months the HIM designee may, instead of using a statistically-valid sample, substitute a random probe sample of at least 30 encounters. If the review of the probe sample shows that the "-GR" modifier was properly attached to at least 29 of the 30 encounters (95 percent accuracy), a 95 percent accuracy rate is reported to CBIO not later than the last working day of the month.

d. If the results of review of any probe sample show that the "-GR" modifier was properly attached to fewer than 29 of the 30 billable encounters which were reviewed, a valid random statistical sample must be selected from the list of bills and a random statistical sample must be used until results from at least two successive months show coding accuracy of 95 percent or more, at which time probe sampling may resume.

e. If the results of any review show inaccurate use of the "-GR" modifier on any billable encounter, the causes for inappropriate use and the corrective action taken must be reported to CBIO.

f. All instances where a "-GR" modifier was inaccurately attached to a billed encounter must be reported to the facility Revenue Officer responsible for billing the encounter, who must report to CBIO the corrective action taken, including cancellation of bills or refunds.

g. In instances where monitoring of a probe or a statistical sample shows greater than 10 percent error rates in attachment of the "-GR" modifier to billed encounters, the Revenue Officer, HIM Director, and CBIO must consult as to methods of ensuring that incorrect billings are not sent, including the potential cessation of billing all encounters with the "-GR" modifier until the causes for the errors is identified and resolved.

h. Success in this process is measured by a demonstrated increase in the accurate attachment of the "-GR" modifier to at least 95 percent of the encounters to which it applies.

3. Monitoring to Ensure Adequate Documentation of Resident Supervision. The third monitoring protocol systemically reviews potentially billable encounters in which residents provided some or all of the care and where the potentially billable encounter is not billable because the "-GR" modifier was not attached.

a. In general, when a "-GR" modifier is not assigned to a billable encounter in which a resident was involved, the cause is:

1. Incomplete Coding: Clinical documentation shows that the resident was properly supervised to support the "-GR" modifier, but the modifier was not assigned.

2. Insufficient Documentation of Resident Supervision: Supervision complied with Handbook 1400.1 requirements, but was not completely documented.

3. Indeterminate supervision: Documentation does not show compliance with Handbook 1400.1 requirements, and compliance with Handbook 1400.1 is indeterminate or known to be insufficient.

NOTE: *To be effective, this protocol requires the interdisciplinary collaboration of Revenue, HIM, Coding, Academic Affiliations or Graduate Medical Education, and CBI teams and the support of the Veterans Integrated Service Network(VISN) and medical center leadership, including the Chief of Staff and Service Chiefs.*

b. This protocol is based on the standard Reasons Not Billable ("RNB") Report, without affecting other existing uses of the RNB Report. Three modifications are made to the RNB Report to support a systemic and routine review of instances where resident encounters cannot be billed. They are:

1. Change standard comment codes used by the medical center in the "RNB Comment" field to include "GR" as the prefix to any comment code assigned by a coder where a resident was involved in delivering care. As an example, if an existing standard code was "NAD," for "Need Additional Documentation," the code would be changed to "GR NAD."

NOTE: *This protocol assumes that standard "RNB" codes are assigned by coders. If standard "RNB" codes are not assigned by a medical center or consolidated coding unit, management needs to consider whether to institute the practice generally, and also needs to consider whether to use the same lexicon of standard "RNB" codes as used by other medical centers or billing units in the medical center's VISN.*

2. Change standard operating procedures for coders to require that, when a coder cannot assign the GR modifier to a billable encounter where a resident provided care, the appropriate GR-prefixed code is entered into the "RNB Comment" field.

NOTE: *At some medical centers, coders automatically email the attending physician if documentation does not support a clinical code. If a response is not received from the attending*

physician, or if the exception is not resolved within 5 working days, a follow-up email is sent to both the accountable clinician and the clinician's service chief. This recommended practice generally results in few, if any, surprises on Coder-Comment RNB reports.

3. On or before the 5th working day of each month, CBIO prepares a separate Coder-Comment RNB report for billable encounters which occurred during the previous month, using the appropriate fileman released by the CBI Office. The month for which the Coder-Comment report is run is called the "month under review" in this protocol. This separate report captures coder-supplied RNB comments. Existing RNB reports can be run and used as they are now.

NOTE: *Use of the CBI-issued Fileman routine to create the Coder-Comment report segregates encounters by specialty, provides information identifying the specific encounter and the amount which could have been billed if the encounter was billable.*

c. The coder-comment RNB report contains comments related to documentation generally, but specifically includes those comments with the GR prefix. These reports are distributed to the HIM designee and are handled as follows:

1. The reports are reviewed by HIM supervisors to confirm the original assignment of the RNB code. In some cases, particularly where documentation was late in arriving, it may be possible for codes to be assigned at the time of this review. In other cases, supervisors may determine the initial coding was incorrect and there is sufficient documentation for assignment of a GR code. In either of these instances, the encounter can be released for billing.

NOTE: *Root causes for changes at this step are investigated and corrected. Results of these monitoring activities need to be confirmed by periodic independent audits conducted by CBI.*

2. After review by HIM supervisors and any corrections, the reports are transmitted to the responsible clinical service chief on or before the 20th of the month following the month under review. The clinical service chief uses the report to support necessary corrective actions in the clinical setting.

(a) Where documentation is inadequate, the Service Chief arranges for addenda to documentation for specific encounters and, as necessary, additional training for the accountable clinicians. Where there is concern about how the documentation is being reviewed by coders, the Service Chief arranges for dialogue between clinicians and HIM staff, as appropriate.

(b) Where required supervision did not occur and thus could not be documented, the Service Chief takes action as needed.

3. On the last business day of each month, a final Coder-Comment RNB report is prepared for billable encounters for the month under review, showing encounters still unresolved as of that date. A copy of this report is transmitted to the Chief of Staff.

d. All reports prepared under this protocol are delivered to the medical center CBIO who prepares summaries in standing reports to the medical center Compliance Committee for

inclusion in CBI Committee minutes. Reports prepared under this protocol which contain patient-identifiable data or protected health information are handled in accordance with VHA and medical center confidentiality requirements.

e. The medical center may, but is not required to, reduce the frequency of this Adequate Documentation monitor to once each calendar quarter when:

1. The exception rate (i.e., the number of billable encounters in which residents delivered services which could not be billed due to the lack of documentation sufficient to support the GR modifier) is reduced to fewer than 5 percent of the total number of billable encounters in which residents delivered services, and

2. This monitoring result is confirmed by an independent audit conducted by CBI.

f. If the result of any quarterly monitoring shows that the exception rate is 5 percent or greater, monthly monitoring is resumed until the exception rate is again less than 5 percent.

g. Success in this process is measured by:

(1) A continued reduction in the dollar amount which could not be billed due to lack of documentation sufficient to support coding, and particularly "-GR" codes;

(2) A continued reduction in the number of potentially billable encounters which could not be billed due to lack of documentation sufficient to support coding, and particularly "-GR" codes.